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L13 and (verify$3 or verification or authoriz$6) same claim$3 same number$3	4

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Search History

DATE: Thursday, May 05, 2005 Printable Copy Create Case

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DB=USPT; PLUR=YES; OP=ADJ			
L14	L13 and (verify$3 or verification or authoriz$6) same claim$3 same number$3	4	L14
L13	L7 and(match$6 or mapp$6)	188	L13
L12	L11 and (automatic$3 or automat$3)same(send$4 or receiv$3) same (indication or identify$3)same (payer or payor or payee or pay$6) same computer$6	1	L12
L11	l7 and (verify$3 or verification or authoriz$6) same claim$3 same number$3	4	L11
L10	l7 and (verify$3 or verification or authoriz$6) same claim$3 same number$3 same (automatic$3 or automat$3)	0	L10
L9	L8 and (automatic$3 or automat$3)same (send$4 or receiv$3) same (payer or payor or payee or pay$6) same computer$6	2	L9
L8	L7 and (match$6 or mapp$6)same claim$3 same number$3	3	L8
L7	(work$3 adj compensat$6)	625	L7

L6	(work$3 adj compensat$6)same claim$3 same number$3	0	L6
L5	match$3 same (work$3 adj compensat$6)same claim$3 same number$3	0	L5
L4	match$3 near10 (work$3 compensat$6)near10 claim$3	0	L4
L3	match$3 near10 (work$3 compensat$6)near10 claim$3 near10 automatic$4 near pay$3 near computer$	0	L3
L2	4987538.pn.	1	L2
L1	5544044.pn.	1	L1

END OF SEARCH HISTORY

L9: Entry 2 of 2 File: USPT Nov 27, 2001

DOCUMENT-IDENTIFIER: US 6324516 B1
TITLE: System and apparatus for utilization review of medical claims

Brief Summary Text (5):
The escalating cost of medical care, especially in the area of workers compensation, has led many insurance companies to adopt a strategy known as managed care. A primary component of managed care is a set of rules that specify, for a given injury, the type of treatments, and the quantity of such treatments which are allowed. These rules come from several different sources, namely state regulations, preferred provider organization (PPO) agreements between the providers and payors, and private rules written by the insurance companies. Most of the fifty states have formulated rules covering the type and quantity of medical treatments which are allowable and under what conditions they are allowable based on a given injury. Some state rules are very specific and leave little room for adjustment. Other states' rules are rather loose and function more in the nature of guidelines. PPO agreements are blanket agreements between payors, providers and patients that, like the state rules, list the types and quantity of medical treatments that will be authorized for a given diagnosis. Most PPO agreements also specify the maximum allowable fees for various medical services.

Brief Summary Text (10):
A significant problem in the art of UR has been the inability for payors to effectively correlate the UR agreements with the bills actually received and paid. Thus, in the example above, if the patient stayed in the hospital for five days, instead of the authorized three, the payor might be billed for, and might pay for, five days. This inability to effectively correlate the agreements to the bills has arisen in part from the sheer volume and complexity of the UR agreements and medical bills being processed. The payors have been unable to use computers to automate this task because there has existed no method to code the UR agreement and the medical bill into forms that can be used by the computer, and no method to compare UR agreements to the medical bills. This inability to enforce the UR agreements has resulted in frequent overpayments, and rendering the cost savings attributed to the UR agreements generally illusory.

Detailed Description Text (8):
FIG. 6 shows various data fields of the case header record 600. A case ID field 602 contains a UR vendor case ID which references the UR vendor's identification of a pre-authorization request 105. The UR vendor case ID field 602 is a link from a; UR vendor's case record to a bill review system's case record. Subsequent submissions of records containing the same UR vendor case ID 602 as an existing case header record 600 indicate an update to the existing record. A claim number field 603 contains a payor's 106 (i.e. an insurance carrier's) claim number. A field 604 contains the worker's 101 social security number. The claim number field 603 is used to verify that a claim number is correct and can be used to match a case header record 600 to a claim number if a claim is not found. A name field 606 contains the name of the worker 101. An address field 609 contains the address of the worker 101. The name field 606 and address field 609 can be used to help match the case header record 600 to a claim number 603 if a claim is not found. A field

613 contains the date of the injury 102 to the worker 101. A UR vendor cost field 614 contains a fee that the UR vendor is charging a payor 106 to manage the case 130 and enforce the LUR agreements 107. A UR request date field 615 contains a date that the UR company received a pre-treatment authorization request 105 from a provider 104. A UR request type field 616 contains a code indicating a service being performed by the UR vendor. Under the preferred embodiment, the UR request type field 616 always contains a character string "UM" to indicate that utilization management is being performed. A primary diagnosis field 617 contains a primary diagnosis code for the injury 102 suffered by the worker 101. A secondary diagnosis field 616 contains a secondary diagnosis codes. A group of fields 619, 620 and 621 contain subsequent diagnosis codes. A status field 622 contains a current status of the case 103. The current status field 622 always contains a code indicating one of the following values: "open", "close", "canceled", or "deleted." A PPO identifier field 623 contains a code which identifies which PPO the claimant 101 is to be using.

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